

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS5704AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/04/2011
NAME OF PROVIDER OR SUPPLIER INFINITE CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3821 TOPAZ LAS VEGAS, NV 89121		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted on your facility 3/3/11 through 4/4/11. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds for elderly and disabled persons and/or persons with mental retardation and/or persons with mental illness and/or persons with chronic illness, Category II residents. Complaint #NV00027693 - The allegation regarding the facility failing to take fall risk precautions was substantiated. See Tag Y 0623.	Y 000		
Y 623 SS=D	449.2702(4)(d) Admission Policy NAC 449.2702 4. Except as otherwise provided in NAC 449.275 and 449.2754, a residential facility shall not admit or allow to remain in the facility any person who: (d) Requires skilled nursing or other medical supervision on a 24-hour basis. This Regulation is not met as evidenced by: Based on interview and record review, the facility	Y 623		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 623	Continued From page 1 retained a resident who required skilled nursing and other medical supervision on a 24 hour basis (Resident #1 had 7 falls while living at the facility). Severity: 2 Scope: 1	Y 623			

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